EXCEL ACADEMY CHARTER SCHOOLS

▢ EXCEL ACADEMY CHELSEA	Phone: 617-336-9974	Fax: 617-339-6867
▢ EXCEL ACADEMY GREENWAY	Phone: 857-322-1366	Fax: 617-674-3429
▢ EXCEL ACADEMY EAST BOSTON	Phone: 617-874-4093	Fax: 617-419-1122
▢ EXCEL ACADEMY CHARTER HIGH SCHOOL	Phone: 617-440-7021	Fax: 617-674-3427
▢ EXCEL ACADEMY RHODE ISLAND	Phone: 401-680-6087	Fax: 401-619-0010

Authorization for the Exchange of Health Information

Student/Patient Name: _____
Date of Birth: _____
Healthcare Provider (Doctor) Name: _____
Phone Number: _____ Fax Number: _____

The purpose of this form is to facilitate communication between a school nurse and/or school counselor, and the child's Health care provider, for the purposes of optimizing the student's learning experience. The school nurse may share information provided in this medical report with appropriate members of the educational and support team for use in meeting the student's health, safety and educational needs. This will be done on a "need to know" basis, in a confidential manner and may also include communication between health provider and school nurse to facilitate this process. Likewise, the medical provider may share information with the hospital or clinical team. Only those areas listed below will be shared.

What information will this allow the Health Care Provider to share with the School? All components of the student's medical record, including notes from sick and well visits, immunization records, current prescriptions and medications, allergies, physical or mental health diagnoses or conditions, injuries and any relevant recommendations or restrictions, and discharge summaries. All of the above information will be shared with the goal of optimizing the student's learning experience.

What information will this allow the School to share with the Health Care Provider?
All components of the student's cumulative educational record, including notes and logs from the nurse's office, attendance, disciplinary, and grade records, teacher and staff observations related to student safety and well-being, and relevant special education records or evaluations (if applicable). All of the information above will be shared with the goal of optimizing the student's learning experience.

Authorization

This authorization is valid for the duration of the student's enrollment at the school. I understand that it is my responsibility to provide the School with updated information concerning my student, and that the School shall not be responsible for any errors or omissions caused by my failure to provide the School with updated information. Nothing in this authorization replaces my responsibility to have my student undergo a Physical Examination and to obtain Immunizations as required by Massachusetts law. This authorization will expire on the last day of my student's enrollment at the School. I understand that I may revoke this authorization at any time by submitting a written notice of the withdrawal of my consent. I recognize that health records, once received by the School, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act and related Massachusetts laws and regulations. By agreeing to allow communication between the Health care provider and designated school health employees, I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent Signature: _____ Date: _____

Student Signature*: _____ Date: _____
*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Massachusetts, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.